

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 13058										
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Wynne</b>			c. LENGTH OF STAY IN 1b <b>2 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural St. Inigoes</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <b>Carroll</b> Middle <b>Matthews</b> Last <b>Armstrong</b>					4. DATE OF DEATH <b>Nov. 5, 1961</b> Month <b>Nov.</b> Day <b>5</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1940</b>		9. AGE (In years last birthday) <b>21</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Carroll Gordon</b>					14. MOTHER'S MAIDEN NAME <b>Mary Francis Armstrong</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>219-34-9054</b>		17. INFORMANT <b>Mary F. Armstrong</b>			Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>850 X Suffocation due to Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from Oyster Boat, Wynne St Inigoes Md.</b>								
20c. TIME OF INJURY Month, Day, Year <b>11-8-1961</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Smiths Creek</b>		20f. (City or town) <b>Wynne St Inigoes</b>		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>W.H. Patrick M.D.</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>William H. Patrick M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/11/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) <b>St. Inigoes</b>		(State) <b>Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>					ADDRESS <b>Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M-

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

13059

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Leonardtown</b>		LENGTH OF STAY (in this place) <b>53 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>X Rural Avenue</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Mary's Hospital</b>				STREET ADDRESS (If rural give location) <b>/</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Joseph Bostwick</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 21, 19 61</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>June 17, 1866</b>		<b>9. AGE last birthday</b> <b>95</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Atlantic Ocean</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>?</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Elmer G. Spalding Avenue, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE</b> (A) <b>Myocardial Failure</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Days</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <b>Coronary Insufficiency</b>				<b>no,</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <b>ASCVD</b>				<b>yes</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>4/18, 19 61</b> , to <b>11/21, 19 61</b> , that I last saw the deceased alive on <b>11/21, 19 61</b> , and that death occurred at <b>10 P.</b> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <b>11/22/61</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>11/24/61</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Sacred Heart Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b> <b>NOV 28 '61</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Clarke Mattingley</b>		<b>LOCATION</b> (City, town, or county) <b>Bushwood, Maryland</b>	
<b>DATE</b>				<b>ADDRESS</b> <b>Leonardtown, Md.</b>			

INSTITUTION

RECEIVED  
JAN 10 1907  
U.S. DEPT. OF JUSTICE  
RECEIVED  
JAN 10 1907  
U.S. DEPT. OF JUSTICE

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 100

1. Name of deceased (Print name)

2. Date of death

3. Age (Years, Months, Days)

4. Sex

5. Marital status

6. Place of birth

7. Date of birth

8. Place of death

9. Name of physician

10. Name of undertaker

11. Name of funeral home

12. Date of interment

13. Name of cemetery

14. Name of funeral home

15. Name of funeral home

16. Name of funeral home

17. Name of funeral home

18. Name of funeral home

19. Name of funeral home

20. Name of funeral home

21. Name of funeral home

22. Name of funeral home

23. Name of funeral home

24. Name of funeral home

25. Name of funeral home

26. Name of funeral home

27. Name of funeral home

28. Name of funeral home

29. Name of funeral home

30. Name of funeral home

31. Name of funeral home

32. Name of funeral home

33. Name of funeral home

34. Name of funeral home

35. Name of funeral home

36. Name of funeral home

37. Name of funeral home

38. Name of funeral home

39. Name of funeral home

40. Name of funeral home

41. Name of funeral home

42. Name of funeral home

43. Name of funeral home

44. Name of funeral home

45. Name of funeral home

46. Name of funeral home

47. Name of funeral home

48. Name of funeral home

49. Name of funeral home

50. Name of funeral home

51. Name of funeral home

52. Name of funeral home

53. Name of funeral home

54. Name of funeral home

55. Name of funeral home

56. Name of funeral home

57. Name of funeral home

58. Name of funeral home

59. Name of funeral home

60. Name of funeral home

61. Name of funeral home

62. Name of funeral home

63. Name of funeral home

64. Name of funeral home

65. Name of funeral home

66. Name of funeral home

67. Name of funeral home

68. Name of funeral home

69. Name of funeral home

70. Name of funeral home

71. Name of funeral home

72. Name of funeral home

73. Name of funeral home

74. Name of funeral home

75. Name of funeral home

76. Name of funeral home

77. Name of funeral home

78. Name of funeral home

79. Name of funeral home

80. Name of funeral home

81. Name of funeral home

82. Name of funeral home

83. Name of funeral home

84. Name of funeral home

85. Name of funeral home

86. Name of funeral home

87. Name of funeral home

88. Name of funeral home

89. Name of funeral home

90. Name of funeral home

91. Name of funeral home

92. Name of funeral home

93. Name of funeral home

94. Name of funeral home

95. Name of funeral home

96. Name of funeral home

97. Name of funeral home

98. Name of funeral home

99. Name of funeral home

100. Name of funeral home

1  
M  
I  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
13073						13060											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. COUNTY			St. Mary's			a. STATE			b. COUNTY								
			MARYLAND						Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS								
Leonardtown			2 days			Rural Abell											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
St. Mary's Hospital																	
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH											
First		Middle		Last		Month		Day		Year							
Ruther		Ignatius		Bowles		November		17,		19 61							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR							
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Nov. 20, 1875		85 yrs.		Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Veterinarian				Maryland		U.S.A.											
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME											
John I. Bowles						Matilda Graves											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address					
no						none						Mrs Neoma B. Mattingly Leonardtown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												unk					
451X DUE TO																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. 19																	
21. I certify that (I) (this hospital) attended the deceased from Nov. 15, 1961, to Nov. 17, 1961, that (I) (we) last saw the deceased alive on Nov. 16, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.																	
22a. SIGNATURE												22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)												22d. ADDRESS					
William D. Boyd M.D.												Leonardtown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial												11/20/61		St. Joseph's Cemetery		Morganza, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley Leonardtown, Maryland												NOV 21 '61		Arthur S. Hanes			

M

I

1907

St. Mary's

Maryland

St. Mary's

Leonardtown

2 days

April 1901

St. Mary's Hospital

Ruther

Legation

Bowles

November 17

01

Male

White

Nov. 11, 1907

35

Veterinarian

Maryland

U.S.A.

John I. Bowles

Medical Graves

none

Mr. Thomas G. Hastings Leonardtown, Maryland

William D. Boyd M.D.

Leonardtown, Maryland

April

11/20/01

St. Joseph's Cemetery

Maryland

1.012126 Hastings Leonardtown, Maryland



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13074

Reg. Dist. No. 13061

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		c. LENGTH OF STAY IN 1b <b>13 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>328 Yorktown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Loran</b> Last <b>Bowman</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1901</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Surveyor</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Bowman</b>				14. MOTHER'S MAIDEN NAME <b>Effie Commins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>WW 11</b>		16. SOCIAL SECURITY NO. <b>035-10-5201</b>		17. INFORMANT <b>Mrs Elizabeth B. Bowman</b> Address <b>same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>42011</b> DUE TO <b>Coronary infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/21/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Milton Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Milton,</b>				22e. (State) <b>Massachusetts</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 21 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>				DATE SIGNED <b>11/17/61</b>			

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13075

13062

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>				e. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ABLE</b> Last <b>BRADBURN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1887</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Vicent Jefferson Bradburn</b>				14. MOTHER'S MAIDEN NAME <b>Bertie Elizabeth Sisson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220 16 8868</b>		17. INFORMANT Address <b>Mary A. Bradburn - Ridge, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Purpura of Acute Rheumatism</b> <b>022 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Later than usual</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Ridge, Maryland</b>		20g. (County)		20h. (State)		20i. (City or town)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> 19 <b>44</b> , to <b>Nov. 7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Oct. 12</b> 19 <b>61</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert F. Fuchs</b>				22b. DATE SIGNED <b>11/8/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert Fuchs, MD</b>	
22d. ADDRESS <b>Leonardtown, Md.</b>				22e. REC'D BY REGISTRAR <b>NOV 14 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		23d. LOCATION (City, town, or county) <b>Ridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24b. ADDRESS		24c. DATE	

10000

CENTRAL DE MEXICO

10000

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13063

13076

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>9days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Moses</b> Middle <b>Briscoe</b> Last <b>Briscoe</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Aberham Briscoe</b>		14. MOTHER'S MAIDEN NAME <b>Classie Jennifer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Francis Briscoe</b>		Address <b>846 Delafield Place N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332 X</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Washington, D. C.</b> DUE TO (c) <b>Interval between onset and death 1 wk</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 21 1961</b> to <b>Nov 27 1961</b> , that I last saw the deceased alive on <b>Nov 21 1961</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mechanicsville, Maryland</b> DATE SIGNED <b>Arthur S. Kraus</b>			
ACTUAL SIGNATURE <b>J. Roy G. GUYNER, M.D.</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>J. Roy G. GUYNER, M.D.</b>		Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Charlotte Hall, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CENTRAL OF DEATH

St. Mary's

St. Mary's

St. Mary's

Charlotte Hall

St. Mary's

St. Mary's

St. Mary's

St. Mary's Hospital

St. Mary's

St. Mary's

75

Aug. 17, 1930

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13077

CERTIFICATE OF DEATH

13064

Items 1 & 2 Film 6502 12/4/61 ink

1. PLACE OF DEATH a. COUNTY <b>ST MARYS</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST MARYS</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHARLOTTE HALL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CHARLOTTE HALL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home</b>				d. STREET ADDRESS <b>1 priv. home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOUISE BLANDFORD BURROUGHS</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 8, 1872</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH H. BLANDFORD</b>				14. MOTHER'S MAIDEN NAME <b>CECELIA MUDD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>EUGENE S. BURROUGHS JR., HUGHESVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>492 X</b> IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>severe, generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5d</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Nov 1961</b> , that (I) (we) last saw the deceased alive on <b>22 Nov 1961</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon W. Burke</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST JOHNS CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>CLINTON, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, WALDORF, MD.</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Finner</b>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Newport</b> d. STREET ADDRESS <b>08X-2</b> a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pauline Cole</b>		4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 25, 1893</b> 9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland U.S.A.</b>
13. FATHER'S NAME <b>James Baker</b>		14. MOTHER'S MAIDEN NAME <b>Liza Nelson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Elinor Bowman</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary infarct</b> DUE TO (b) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 15, 1961</b> to <b>Nov 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 15, 1961</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William D. Boyd M.D.</b>		22b. DATE SIGNED <b>11/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William D. Boyd M.D.</b>		22d. ADDRESS <b>Leonardtown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>		23d. LOCATION (City, town or county) (State) <b>Morganza, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1961</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

M

I

W. Clarke Hastings, Leonardtown, Maryland  
Burial 11/16/61 St. Joseph  
Md.

William D. Boyd N.D.

Leonardtown, Maryland

None

Elliot Bowman

James Baker

Lina Nelson

Housewife

Home

Maryland U.S.A.

Female Colored

X

October 27, 1893

68

Female

Colo

November 16,

61

Leonardtown 21 days

Burial Newport

St. Mary's

Maryland

St Charles

1803

1803

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

130799

13066

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Marys City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>				e. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Fredrick</b> Last <b>Coogan</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1901</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Whitesboro, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lawrence A. Coogan (dec)</b>				14. MOTHER'S MAIDEN NAME <b>Libby Ripka (dec)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1917-1919 577 18 0491</b>		17. INFORMANT <b>Mrs. Be Lee Coogan - St. Marys City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Hypernephroma</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>5 yrs.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anomalous - liver failure.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) <b>none</b>	(County) <b>none</b>		(State) <b>none</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7/25/61</b> 19 <b>61</b> , to <b>11/17</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/17/61</b> 19 <b>61</b> , and that death occurred at <b>3A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Julian S. LANE M.D.</b>				22b. DATE SIGNED <b>NOV 20 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Julian S. LANE M.D.</b>	
22d. ADDRESS <b>Lexington Park, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/21/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 20 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hawks</b>	

1307



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13080

## CERTIFICATE OF DEATH

Reg. Dist. No.

13067

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Hollywood</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grave</b> Middle <b>Mae</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1910</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>24</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philip Cheseldine</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Parker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Fred L. Davis Sr. Hollywood, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ca colon - sigmoid</b> 153.8 DUE TO <b>metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>heart failure</b> (b) <b>heart failure</b> (c) <b>heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11.7.60</b> , 19 <b>60</b> , to <b>11.24</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>11.23.61</b> , 19 <b>61</b> , and that death occurred at <b>4:30</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Frederick A. Samadi</b> M.D.			
PHYSICIAN'S NAME (Type) <b>A. Samadi M. D.</b>		<b>Leonardtown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Nazarene Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

M

Leopardsburg

St. Mary's Hospital

Graves

Female White

Houseside

Phillip Chesapeake

Blanche Parker

Washington, D. C.

U.S.A.

Sept. 16, 1910

Davis

November 18, 1910

15 days

Normal Holliwood

Asylums

St. Mary's

INSTITUTION FOR DEAF

130-10

130-10

St. Charles Washington, Leopardsburg, Maryland

Marion Cemetery

Holliwood, Maryland

A. Samuel N. D.

Leopardsburg, Maryland



**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13081

13068

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mechanicsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>Dolby</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7-1886</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Dolby</u>				14. MOTHER'S MAIDEN NAME <u>MARY Elizabeth Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Bird H. Dolby - 3300 Cheryl Ave. Md</u> Address <u>Cheryl</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carcinomatosis - Intestinal obstruction - Carcinoma of sigmoid</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Electrolyte deficiency</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11.23</u> 19 <u>61</u> to <u>11.28</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>11.28</u> 19 <u>61</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>A. Samadi</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11.28.61</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. SAMADI</u>				22d. ADDRESS <u>LEONARDTOWN - Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec. 1st 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u> ADDRESS <u>1601 Good Hope WASH 20, D.C.</u>				25a. REC'D BY REGISTRAR <u></u> DATE <u>DEC 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

78

I

0

1

SP

12051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13082

## CERTIFICATE OF DEATH

13069

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hollywood</b>		c. LENGTH OF STAY IN lb <b>20 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hollysood</b>	
		d. STREET ADDRESS <b>1</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter Pruitt Dorough</b>		4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1902</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter P. Dorough Sr</b>		14. MOTHER'S MAIDEN NAME <b>Zadie Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-10-9952</b>	
17. INFORMANT <b>Julia L. Dorough</b>		Address <b>Hollywood, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Cachexia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Carcinoma of Brain (Metastatic)</b> DUE TO <b>Primary Carcinoma probably in left kidney</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days (2)</b> <b>2-3 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 5, 1961</b> to <b>11/29, 1961</b> ; that (I) last saw the deceased alive on <b>11/29, 1961</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James P. Jarboe M.D.</b>		22b. DATE SIGNED <b>11/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe M.D.</b>		22d. ADDRESS <b>Great Mills, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/1/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Great Mills, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
ADDRESS <b>Leonardtwn, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

13000000

13000000

M

1

St. Mary's

Kentland

St. Mary's

St. Mary's

Kentland

November 22, 1900

November 22, 1900

November 22, 1900

July 1, 1900

July 1, 1900

U.S.A.

Georgia

Kentland

Kentland

Kentland

Kentland

no

*[Faint, illegible handwritten text]*

Great Mills, Maryland

James P. Jarboe M.D.

Great Mills, Maryland

Great Mills, Maryland

Boonester Cemetery

12, 1901

Great Mills

Boonester Cemetery, Boonester, Maryland

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13083

13070

1. PLACE OF DEATH a. COUNTY <b>ST MARYS</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>9 mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 287</b>				d. STREET ADDRESS <b>22X-1</b>			
3. NAME OF DECEASED (Type or print) <b>Bertha M. Elsey</b>				4. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-10-89</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>school teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Agustus Nutter</b>				14. MOTHER'S MAIDEN NAME <b>Louisia Black</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. <b>220-4088</b>			
17. INFORMANT <b>Mrs Lovella Nutter</b>				Address <b>—</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:  <b>199X</b> IMMEDIATE CAUSE (a) <b>Heart failure</b>            DUE TO (b) <b>Hepatic Comma</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>medastatic Ca</b>            DUE TO (c) <b>medastatic Ca</b> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>—</b></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>in 1961</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>11/11</b> 1961, and that death occurred at <b>97 M</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Beulah Smith</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>M. Bantarch</b>				22d. ADDRESS <b>Leonardtown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11-16-61</b>		<b>NANTICOKE cem</b>		<b>NANTICOKE Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Doshell</b>				25a. REC'D BY REGISTRAR <b>NOV 15 1961</b>			
ADDRESS <b>Porter, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>James D. Doshell</b>			

10000

10000

(A)





**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Leonardtown</u>		LENGTH OF STAY (in this place) <u>D.O.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X Rural Hollywood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DOA St. Mary's Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Francis Louis Garner</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>November 17, 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 4, 1912</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis D. Garner</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hayden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-07-3448</u>		17. INFORMANT & ADDRESS <u>E. Regina Garner Hollywood, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>420/ Acute coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis, coronary</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>July 19, 1955</u> , <b>to</b> <u>Nov., 1961</u> , <b>that I last saw the deceased alive on</b> <u>Nov. 6, 1961</u> , <b>and that death occurred at</b> <u>11:45 P.</u> <b>M.</b> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>[Signature]</u> <b>M.D.</b> <b>ADDRESS</b> (Street, city, town, state) <b>DATE SIGNED</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/21/61</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		LOCATION (City, town, or county) (State) <u>Hollywood, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 21 '61</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

Downloaded At: 11:53 11 September 2009

• • • • •

*(continued)*

Incorporated by Special Act

2234

0121075

## References

5214

1992

Environ Biol Fish (2015) 98:1111–1121

7030710

11/10/02 11:11 AM

JAMES D. HARRIS

844-70-710

\_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13072

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Mary's</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b><br>c. LENGTH OF STAY IN 1b <b>8 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>St. Mary's</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Chaptico</b><br>d. STREET ADDRESS <b>1</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Stephen</b> Middle <b>Judson</b> Last <b>Gough</b>   |   | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>8</b> Year <b>1961</b>  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>July 31, 1894</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postmaster</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>67</b><br>IF UNDER 1 YEAR: Months Days Hours Min. |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Chaptico, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>James J. Gough</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Laura Davis</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>215-36-6970</b>   |  |
| 17. INFORMANT <b>W. Edelen Gough</b>   |   | Address <b>Chaptico, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <b>581.0</b> DUE TO <b>Cirrhosis</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)<br>INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1961</b> to <b>Nov 8, 1961</b> ; that (I) (we) last saw the deceased alive on <b>Nov 8, 1961</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <b>W.D. Boyd</b>  |   | 22b. DATE SIGNED <b>11/9/61</b>  | 22c. PHYSICIAN'S NAME (Type) <b>William D. Boyd M.D.</b>                             |
| 22d. ADDRESS <b>Leonardtwn, Maryland</b>   |   | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>11/11/61</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>   | 23d. LOCATION (City, town or county) (State) <b>Morganza, Maryland</b>               |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>   |   | 25a. REC'D BY REGISTRAR <b>NOV 15 '61</b>  |  |
| ADDRESS <b>Leonardtwn, Maryland</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>  |  |

10001

10001

St. Mary's

Maryland

St. Mary's



Chapelle

June

8 days

Leominster

St. Mary's Hospital

10

November 8

Gough

Judson

Stephen

67

July 21, 1894

White

White

U.S.A.

Maryland

Chapelle

Postmaster

James Davis

James J. Gough

St. Mary's Hospital, Maryland

Leominster, Maryland

William D. Boyd M.D.

Maryland

Postmaster

St. Joseph

11 of 11

Postmaster

St. Mary's Hospital, Maryland

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |  |  |  |
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |   |  |  |  |  |  |
| 13086 CERTIFICATE OF DEATH 13073  |  |  |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY St. Mary's MARYLAND  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE Maryland b. COUNTY St. Mary's |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown  |  |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland                                       |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital  |  |  |  |  |  | 4. STREET ADDRESS 1   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Albert Spencer Hammett  |  |  |  |  |  | 4. DATE OF DEATH November 16 19 61  |  |  |  |  |  |
| 5. SEX Male   |  | 6. COLOR OR RACE White   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH Sept. 23, 1884   |  | 9. AGE (In years birth day) yrs. 80                                      |  | IF UNDER 1 YEAR Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government  |  |   |  | 11. BIRTHPLACE (County & State, or foreign country) St. Mary's -Maryland |  | 12. CITIZEN OF WHAT COUNTRY U S        |  |
| 13. FATHER'S NAME Spencer Hammett   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME Katherine Johnson  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  | 16. SOCIAL SECURITY NO. (If yes give war or dates of service)  |  | 17. INFORMANT Thomas Hammett  |  | 2815 63rd Ave. Cheverly, Md.   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Failure<br>(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cor. Insufficiency<br>(c) ASCVD |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH hours DAYS(2) yst.                      |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 6 1961, to 11/16 1961, that (I) (we) last saw the deceased alive on 11/16 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.  |  |  |  |  |  |   |  |  |  |  |  |
| 22a. SIGNATURE James P. Jarboe M.D.   |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED 11/16/61  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) James P. Jarboe, M.D.  |  |  |  |  |  | 22d. ADDRESS Great Mills, Md.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 23b. DATE THEREOF 11-18-1961   |  | 23c. NAME OF CEMETERY OR CREMATORY Wash 308  |  | 23d. LOCATION (City, town or county) Wash, D.C. (State)   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly  |  |  |  | ADDRESS 131-11 SE Wash 308   |  | 25a. REC'D BY REGISTRAR DATE NOV 20 '61   |  | 25b. REGISTRAR'S SIGNATURE O. Thos S. Harris                             |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

(O)

(1)

BP

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                    |  |  |  |   |  |   |  |   |  |
|--|--|------------------------------------|--|--|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                    |  |  |  |   |  |   |  |   |  |
| CERTIFICATE OF DEATH   |  |                                    |  |  |  |   |  |   |  |   |  |
| 13087  |  |                                    |  |  |  |   |  |   |  |   |  |
| 13074  |  |                                    |  |  |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Mary's</b>   |  |                                    |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>St. Mary's</b> |  |   |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Leonardtwn</b>  |  |                                    |  | c. LENGTH OF STAY IN b<br><b>7 days</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lexington Park</b> |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Mary's Hospital</b>   |  |                                    |  | d. STREET ADDRESS<br><b>2 Madison Avenue</b>   |  |   |  | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Thomas Hillary Harris</b>  |  |                                    |  | 4. DATE OF DEATH<br><b>November 3, 1961</b>  |  |   |  |   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Colored</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 11, 1882</b> |  | 9. AGE (In years last birthday)<br><b>79 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>220-01-3306</b>  |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>Henry Harris</b>   |  |                                    |  | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |  |   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |                                    |  | 16. SOCIAL SECURITY NO.<br><b>220-01-3306</b>  |  |   |  | 17. INFORMANT<br><b>Mary W. Harris Same as # 2</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Failure</b><br><b>290.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b><br>(c) <b>Pericardial Anemia</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>ASCVD</b> |  |                                    |  |  |  |   |  |   |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>hrs. Day months</b>   |  |                                    |  |  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                    |  |  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                    |  |  |  |   |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |                                    |  |  |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |                                    |  |  |  |   |  |   |  |   |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |                                    |  |  |  |   |  |   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                                    |  |  |  |   |  |   |  |   |  |
| 20f. (City or town) (County) (State)   |  |                                    |  |  |  |   |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1961</b> to <b>11/3/61</b> , that (I) (we) last saw the deceased alive on <b>11/3/61</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.  |  |                                    |  |  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>James P. Jarboe M.D.</b>  |  |                                    |  |  |  |   |  |   |  |   |  |
| 22b. DATE SIGNED   |  |                                    |  |  |  |   |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James P. Jarboe M.D.</b>  |  |                                    |  |  |  |   |  |   |  |   |  |
| 22d. ADDRESS<br><b>Great Mills, Maryland</b>   |  |                                    |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                    |  |  |  |   |  |   |  |   |  |
| 23b. DATE THEREOF<br><b>11/7/61</b>  |  |                                    |  |  |  |   |  |   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Cemetery</b>   |  |                                    |  |  |  |   |  |   |  |   |  |
| 23d. LOCATION (City, town or county) (State)<br><b>Lexington Park, Md.</b>   |  |                                    |  |  |  |   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. Clarke Mattingley</b>  |  |                                    |  |  |  |   |  |   |  |   |  |
| ADDRESS<br><b>Leonardtwn, Maryland</b>   |  |                                    |  |  |  |   |  |   |  |   |  |
| 25a. REC'D BY REGISTRAR<br><b>NOV 9 '61</b>  |  |                                    |  |  |  |   |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |                                    |  |  |  |   |  |   |  |   |  |

W. O. Clarke Huntington, Leonardtown, Maryland  
Buried 11/7/01 Lion Cemetery

James P. Jarboe M. D. Great Mills, Maryland

Lexington Park, Md.

James P. Jarboe M. D.  
Great Mills, Maryland

James P. Jarboe M. D.  
Great Mills, Maryland

Henry Harris

former

240 81-3302

Maryland

U.S.A.

Male Colored

May 11, 1902

to

Thomas Hilary

Harris

November 3,

01

St. Mary's Hospital

2 Madison Avenue

Leonardtown 7 days

Lexington Park

St. Mary's

Maryland

St. Mary's

13077

13077

1  
FOR STATE  
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |  |   |  |   |  |   |  |  |  |
|---|--|-------------------------------|--|---|--|---|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |  |   |  |   |  |   |  |  |  |
| 13088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                               |  |   |  |   |  |   |  | 13075  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>   |  |                               |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>St. Marys</b> |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>   |  |                               |  |   |  | c. LENGTH OF STAY IN 1b   |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Marys Hospital</b>   |  |                               |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Loveville</b>                                  |  |   |  |  |  |
| d. STREET ADDRESS   |  |                               |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOSEPH</b> Middle <b>DANIEL</b> Last <b>HISTON</b>  |  |                               |  |   |  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>11</b> Year <b>1961</b>  |  |   |  |  |  |
| 5. SEX<br><b>M</b>  |  | 6. COLOR OR RACE<br><b>W.</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 19, 1939</b>   |  | 9. AGE (In years last birthday) <b>22</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>22</b> Days <b>19</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>                    |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |                               |  | 13. FATHER'S NAME<br><b>Daniel D. Histon</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Eileen Brosnan</b>                                       |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                               |  | 16. SOCIAL SECURITY NO.<br><b>216-38-5132</b>   |  |   |  | 17. INFORMANT<br><b>Daniel D. Histon 3101 W. Aculpoco Drive West Hollywood, Florida</b> |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Gunshot wound of chest and left lung</b><br>(c) <b>981X</b><br>DUE TO<br>(a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                               |  |   |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>shot during an altercation</b>                            |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>5:15 P.M. Nov. 11, 1961</b>   |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>restaurant</b>   |  | 20f. (City or town)<br><b>Charlotte Hall St. Marys Md.</b>                              |  | (County) (State)                                   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county)<br><b>Nov 12, 1961 700 Fleet St. Baltimore</b> |  |                               |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Howard Shaub</b>   |  |                               |  | EXAMINER'S NAME (Type)<br><b>Howard Shaub</b>   |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                               |  | 22b. DATE THEREOF<br><b>Nov. 14 1961</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Josephs</b>   |  | 22d. LOCATION (City, town, or country) (State)<br><b>Morgans Md.</b>                    |  |  |  |
| 23. FUNERAL DIRECTOR<br><b>McLorpe Mattingly Leonardtown, Md.</b>   |  |                               |  |   |  | 24a. REC'D BY REGISTRAR<br><b>NOV 21 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                                    |  |  |  |

(M)

(1)

Inspector

Construction

Washington, D.C. U.S.A.

Daniel D. Hinton

Elmer Brennan

Daniel D. Hinton 2101 A. Koenig Drive  
West Hollywood, Florida

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13089 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13076

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>                |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>California</b>   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>California</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Rural</b>  |  |  |  | d. STREET ADDRESS<br><b>Rural</b>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>PANSEY MAUDE HUGHES</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>5</b> Year <b>1961</b>   |  |  |  |
| SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 22, 1909</b>                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>domestic</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Oklahoma</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                 |  |
| 13. FATHER'S NAME<br><b>William P. Fay</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Alberta P. Humphrey</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>257 07 6330</b>  |  | 17. INFORMANT<br><b>Carl N. Hughes - California, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>812X MULTIPLE EXTREME INJURIES</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>PEDDESTRIAN HIT BY AUTO</b> |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>6:45</b> p.m. <b>11-5-1961</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>           |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>ROUTE 235</b>  |  | 20f. (City or town) (County) (State)<br><b>CALIFORNIA ST. MARYS MD</b>     |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Wm. D. Boyd</b>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type)<br><b>Wm. D. Boyd MD</b>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
|   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |
|   |  |  |  | DATE SIGNED<br><b>11/6/61</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 22b. DATE THEREOF<br><b>11/7/61</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Lawn</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Norfolk, Virginia</b> |  |
| 23. FUNERAL DIRECTOR<br><b>P.B. Robinson - Leonardtown, Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 9 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thoms</b>                       |  |

MEDICAL CERTIFICATION

15045

13000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

1

2

3

4

5

6

7

8

9

10

11

12

SIGNATURE OF MEDICAL EXAMINER

SIGNATURE OF WITNESS

TESTED BY MEDICAL EXAMINER

DATE

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER

1

2

3

4

5

6

7

8

9

10

11

12

RECEIVED BY MEDICAL EXAMINER

SIGNATURE OF MEDICAL EXAMINER



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |                                    |  |   |   |                                |  |                                |
|--|------------------------------------|--|---|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH  |                                    |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED   |                                |  |                                |
| COUNTY <b>St. Mary's</b>   |                                    | MARYLAND   |   | STATE <b>Maryland</b>   |                                | COUNTY <b>St. Mary's</b>   |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>Leonardtwn</b>  |                                    | LENGTH OF STAY (in this place)<br><b>14 days</b>                       |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>X Rural Avenue</b> |                                |  |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>St. Mary's Hospital</b>  |                                    |  |   | STREET ADDRESS (If rural give location)   |                                |  |                                |
| 3. NAME OF DECEASED (Type or Print)<br><b>Margaret A. Countiss Jones</b>   |                                    |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>November 18, 19 61</b>                                  |                                |  |                                |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><b>Married</b>     | 8. DATE OF BIRTH<br><b>June 1, 1899</b> | 9. AGE last birthday<br><b>62</b> yrs.  | IF UNDER 1 YEAR<br>Months Days |  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                       |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                    |                                |
| 13. FATHER'S NAME<br><b>William Young</b>  |                                    |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Frances Bowling</b>   |                                |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><b>no</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>none</b>                                 |   | 17. INFORMANT & ADDRESS<br><b>Paul N. Butler 5922 -13th St.N.W.</b>                                 |                                |  |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                    |  |   | 18. MEDICAL CERTIFICATION<br><b>Washington, D. C.</b>   |                                | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks.</b>                |                                |
| 420.1 IMMEDIATE CAUSE (A)<br>ANTECEDENT CAUSE(S) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE<br>STATING UNDERLYING CAUSE LAST.<br>(B)<br>(C)  |                                    |  |   | <b>Coronary Infarct</b>   |                                |  |                                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                    |  |   |   |                                |  |                                |
| 19a. DATE OF OPERATION   |                                    | 19b. MAJOR FINDINGS OF OPERATION                                       |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |                                |  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |                                |  |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 21e. INJURY OCCURRED   |   | 21f. HOW DID INJURY OCCUR?  |                                |  |                                |
| 22. I hereby certify that I attended the deceased from <b>Oct 15</b> , 19 <b>61</b> , to <b>Nov 18</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Nov 17</b> , 19 <b>61</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above. |                                    |  |   |   |                                |  |                                |
| SIGNATURE<br><b>W. D. Bad</b>  |                                    |  |   | ADDRESS (Street, city, town, state)<br><b>Leonardtwn</b>  |                                | DATE SIGNED<br><b>11/19/61</b>                                   |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                                    | DATE THEREOF<br><b>11/22/61</b>  |   | NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart</b>  |                                | LOCATION (City, town, or county) (State)<br><b>Bushwood, Md.</b> |                                |
| 24. REC'D BY REGISTRAR<br>DATE<br><b>NOV 21 '61</b>  |                                    | REGISTRAR'S SIGNATURE<br><b>Charles S. Kinn</b>                        |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. Clarke Mattingley</b> ADDRESS<br><b>Leonardtwn, Md.</b>   |                                |  |                                |

1. *Journal of the American Medical Association*, 1964; 191: 1000-1001.

REVISED

1971-72 32

Source: *U.S. Census Bureau, Current Population Reports, 1990*

1044

23

1991-1992

60144

heredity

22

2004

1999

baplyak

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

*Journal of Management Education*

Paul M. Butler - 1968 - 1969

© 2001 Blackwell Science Ltd

62

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13091

## CERTIFICATE OF DEATH

13078

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>St. Mary's</b> <span style="float: right;"><b>MARYLAND</b></span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural Scotland</b> <span style="float: right;"><b>19 years</b></span><br>c. LENGTH OF STAY IN 1b<br><b>19 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;"><b>St. Mary's</b></span><br>b. COUNTY<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural Scotland</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <b>Joseph</b> Middle <b>Richard</b> Last <b>Knott</b>   |  |  | <b>4. DATE OF DEATH</b><br>Month <b>November</b> Day <b>3</b> Year <b>19 61</b> |  |  |  |  |
| <b>5. SEX</b><br><b>Male</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>  |   | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  |  |  |
| <b>8. DATE OF BIRTH</b><br><b>August 10, 1901</b>  |  | <b>9. AGE</b> (In years last birthday) <b>60</b> yrs.  |   | <b>10. IF UNDER 1 YEAR</b><br>Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Waterman</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Waterman</b>  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Maryland</b>  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>   |  |  |   |  |  |  |  |
| <b>13. FATHER'S NAME</b><br><b>William Henry Knott</b>   |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Mary Elizabeth Goddard</b>                |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown)  |  | <b>16. SOCIAL SECURITY NO.</b><br>(If yes give war or dates of service)  |   | <b>17. INFORMANT</b><br>Address<br><b>Mrs Louise K. Simpkins Ridge, Maryland</b>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>(b) <b>Myocardial Infarction</b><br>(c) <b>ASCVD</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.   |  |  |   |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)               |   |  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| <b>20f. (City or town)</b><br><b>19</b>  |  | <b>20g. (County)</b><br><b>19</b>  |   | <b>20h. (State)</b><br><b>19</b>   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 1961</b> <b>to</b> <b>11/3</b> <b>1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>11/3</b> <b>1961</b> , <b>and that death occurred at</b> <b>11/3</b> <b>M.</b> , <b>from the causes and on the date stated above.</b>  |  |  |   |  |  |  |  |
| <b>22a. SIGNATURE</b><br><b>James P. Jarboe M.D.</b>   |  |  |   | <b>22b. DATE SIGNED</b><br><b>11/3/61</b>  |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>James P. Jarboe M.D.</b>   |  |  |   | <b>22d. ADDRESS</b><br><b>Great Mills, Maryland</b>  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |  | <b>23b. DATE THEREOF</b><br><b>11/6/61</b>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>St. Michael's</b>  |  |  |  |
| <b>23d. LOCATION (City, town or county)</b><br><b>Ridge, Maryland</b>  |  | <b>23e. (State)</b><br><b>Maryland</b>   |   |  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>W. Clarke Mattingley Leonardtown, Maryland</b>   |  |  |   | <b>25a. REC'D BY REGISTRAR</b><br><b>NOV 9 '61</b>   |  |  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kraus</b>  |  |  |   | <b>25c. DATE</b><br><b>NOV 9 '61</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

13078

13001

St. Mary's

Maryland

St. Mary's

Scotland

19 years

19 years

19 years

19 years

61

November 3, 1901

Knott

Knott

Knott

60

August 10, 1901

White

White

U.S.A.

Maryland

Maryland

Mary Elizabeth Goddard

William Henry Knott

Mrs. Louise A. Simpson Higgs, Maryland

Maryland

Great Mills

James P. Jarboe H.D.

Maryland

Ridge

St. Michael's

11/8/01

11/8/01

W. Clarke Hattaway, Leesport, Maryland

may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13092

CERTIFICATE OF DEATH

Reg. Dist. No. 13079

|  |                                  |  |                                     |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>                  |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Leonardtown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>X Charlotte Hall, Md.</b>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>St. Mary's Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LARGEN</b> Middle <b>LARGEN</b> Last <b>LARGEN</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>13</b> Year <b>1961</b>   |                                     |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       | 8. DATE OF BIRTH<br><b>11-12-61</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>—</b>   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>—</b> Days <b>—</b> Hours <b>2</b> Min. <b>7</b>   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>---</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. of America</b>  |                                     |
| 13. FATHER'S NAME<br><b>Harry Wade Largen</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Hilda V. Williams</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>---</b>  |                                     |
| INFORMANT<br><b>mother</b>   |                                  | Address<br><b>Charlotte Hall, Md.</b>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Congenital Anomalies</b><br>75 2X DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost.<br>(b) DUE TO<br>(c) DUE TO |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr.</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Hydrocephalus, osteoblast crisis, palete</b>   |                                  |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.  |                                  |  |                                     |
| ACTUAL SIGNATURE<br><b>David L. Mossman</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>Mechanicsville, Maryland</b> DATE SIGNED <b>11-15</b>   |                                     |
| PHYSICIAN'S NAME (Type)<br><b>David L. Mossman, M.D.</b>   |                                  | <b>Mechanicsville, Maryland</b>  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11-13-61</b>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Aloysius</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Leonardtown, Md</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. G. Mattingly</b>   |                                  | ADDRESS<br><b>Leonardtown, Md</b>  |                                     |
| 24a. REC'D BY REGISTRAR<br><b>NOV 21 1961</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>   |                                     |

2078172 2v2

1.1.2004 11:44:54 - 1.1.2004 11:44:54 - 1.1.2004 11:44:54

— — —



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13080

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Mary's</u><br><u>Lexington Park</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u><br>d. STREET ADDRESS <u>Hill Trailer Court</u> |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |  | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>St. Mary's Hospital</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>RUTH</u> Middle <u>M.</u> Last <u>STADWICK</u>  |  | 4. DATE OF DEATH<br>Month <u>November</u> Day <u>20</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>10/12/61</u>                                 |
| 9. AGE (In years last birthday)<br>yrs. <u>1</u> Months <u>1</u> Days <u>10</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><u>Leonardtwn, Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>   |  | 13. FATHER'S NAME<br><u>John Stadwick</u>  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Bonita M. Morgan</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)   |   |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>John Stadwick - Lexington Park, Md</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis</u><br><u>525X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED<br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) <u>11/21/61</u> |  |  |   |
| ACTUAL SIGNATURE <u>Howard G. Shaub</u><br>EXAMINER'S NAME (Type) <u>HOWARD G. SHAUB, MD.</u>  |  | 22a. NAME OF CEMETERY OR CREMATORY<br><u>Holy Face Cemetery</u>  |   |
| 22b. DATE THEREOF<br><u>11/24/61</u>   | 22c. LOCATION (City, town, or country)<br><u>Great Mills, Md.</u>  | 22d. LOCATION (City, town, or country) (State)   |   |
| 23. FUNERAL DIRECTOR<br>ADDRESS<br><u>P. B. Robinson</u> <u>Leonardtwn, Md.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 28 '61</u>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |  |  |   |

2078202XV5

0269251

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 9 Film G301 11/21/61 iwk

13094

13082

|  |                                 |  |  |   |   |  |  |
|--|---------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Mary's</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b><br>c. LENGTH OF STAY IN 1b <b>2 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>   |                                 |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Drayden</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Mary E. Travis</b>   |                                 |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>10</b> Year <b>1961</b> |   |   |  |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Nov. 22, 1891</b>                                    |   | 9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>      |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |
| 13. FATHER'S NAME <b>Stephen Dyson</b>   |                                 |  | 14. MOTHER'S MAIDEN NAME <b>E. Elizabeth Milburn</b>                     |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                                 | 16. SOCIAL SECURITY NO. <b>none</b>  | 17. INFORMANT <b>James E. Travis Tall Timbers, Maryland</b><br>Address   |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (e) <b>Myocardial Failure</b><br/><b>420.1</b> DUE TO <b>Chronic Insufficiency</b><br/>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>HAS CVD</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus</b></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>days</b><br/><b>yes</b></p> </div> </div> |                                 |  |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 |  |  |   |   |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |  |  |   |   |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. <b>19</b> p.m.  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |  |  |
| 20f. (City or town)  |                                 | 20g. (County)  |  | 20h. (State)  |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1961</b> to <b>11/10/61</b> , that (I) (we) last saw the deceased alive on <b>11/10/61</b> , and that death occurred at <b>11/10/61</b> , from the causes and on the date stated above.  |                                 |  |  |   |   |  |  |
| 22a. SIGNATURE <b>James P. Jarboe</b>  |                                 |  | 22b. DATE SIGNED <b>11/12/61</b>   |   |   |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe M.D.</b>   |                                 |  | 22d. ADDRESS <b>Great Mills, Maryland</b>                                |   |   |  |  |
| 23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>  |                                 | 23b. DATE THEREOF <b>11/13/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>   |   |  |  |
| 23d. LOCATION (City, town or county) <b>Valley Lee, Maryland</b>   |                                 | 23e. (State)   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>   |                                 |  | 25a. REC'D BY REGISTRAR <b>NOV 15 '61</b>                                |   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>  |                                 |  |  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1881

St. Mary's

Maryland

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's Hospital

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's